

Registration District No. 450

Primary Registration District No. 5615

1. PLACE OF DEATH:  
(a) County LACLEDE  
(b) City or town BUCLARE Twp. P.  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
St. Joseph R. H.  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 1  
(Specify whether  
In this community Always  
years, months or days)

3. (a) PRINT FULL NAME SARAE MITCHELL  
3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

4. Sex Female 5. Color or race W  
6. (a) Single, widowed, married, divorced Widowed  
6. (b) Name of husband or wife W-H-MITCHELL 6. (c) Age of husband or wife if alive \_\_\_\_\_ years  
7. Birth date of deceased APR 20, 1858  
(Month) (Day) (Year)

8. AGE: Years 82 Months 10 Days 4 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

9. Birthplace LACLEDE CO MO  
(City, town, or county) (State or foreign country)

10. Usual occupation HOUSE WIFE

11. Industry or business \_\_\_\_\_

MOTHER FATHER { 12. Name FRANKLIN GOODWIN  
13. Birthplace U.S.  
(City, town, or county) (State or foreign country)  
14. Maiden name AMANDA HOEDER  
15. Birthplace U.S.  
(City, town, or county) (State or foreign country)

16. (a) Informant Phyllis G. Gorton  
(b) Address St. Joseph R. H.

17. (a) Burial (b) Date thereof 1 26 41  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation St. Joseph R. H.

18. (a) Signature of funeral director Palmer

(b) Address Tobacco 1115

19. (a) Feb 10 - 1941 (b) W. A. Atkins  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:  
(a) State Mo (b) County Clatsop 53  
(c) City or town Rural  
(If outside city or town limits, write "RURAL")  
(d) Street No. R. 1. Steyer  
(If rural, give location)  
(e) If foreign born, how long in U. S. A.? \_\_\_\_\_ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan day 24  
year 1941 hour 11 minute 55 P. M.

21. I hereby certify that I attended the deceased from 1-24-1941 to 1-24-1941  
that I last saw her alive on 1-24- 1941  
and that death occurred on the date and hour stated above.

Immediate cause of death Embolicism  
Due to aortic stenosis  
Due to \_\_\_\_\_  
Other conditions g.g.w  
(Include pregnancy within 3 months of death)

Major findings: \_\_\_\_\_  
Of operations \_\_\_\_\_  
Of autopsy \_\_\_\_\_

Duration 10 yrs.  
PHYSICIAN \_\_\_\_\_  
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:  
(a) Accident, suicide, or homicide (specify) \_\_\_\_\_  
(b) Date of occurrence \_\_\_\_\_  
(c) Where did injury occur? \_\_\_\_\_  
(City or town) (County) (State)  
(d) Did injury occur in or about home, on farm, in industrial place, in public place? \_\_\_\_\_

While at work? \_\_\_\_\_ (Specify type of place)  
(e) Means of injury \_\_\_\_\_

23. Signature W. A. Hamilton (M. D. or other) \_\_\_\_\_  
Address Sebanon, Mo Date signed 1-25-41

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

RECEIVED

District Health Officer No. 7,

District File Number 3-41-385

Date Filed 2-17-41

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**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....

....., Registered Apprentice No.....  
working under my personal supervision.

Signed.....

..... Licensed Embalmer No.....

..... P. O. Address.....

**Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)**

**If this body is not embalmed, fact should be so stated above.**